

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

4395

04388

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN lb <b>17 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Victoria</b>		First <b>Regalia</b>	Middle <b>Barnes</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1900</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Chambers</b>		14. MOTHER'S MAIDEN NAME <b>Etta Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-20-7274</b>	
17. INFORMANT <b>Ethel Hamilton, Chestertown, Md. (daughter).</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia and atelectasis of left lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Complete paralysis</b> (c) <b>Operative clipping, aneurism, rt ant. cerebral artery</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>about 3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tracheotomy and arterial hypertension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 24 1961</b> to <b>Apr 10 1961</b> , that (I) (we) last saw the deceased alive on <b>Apr 10 1961</b> , and that death occurred at <b>6:20 PM</b> the causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Farr</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>		22d. ADDRESS <b>Chestertown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 15, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Janes Cemetery</b>		23d. LOCATION (City, town, or county) <b>near Chestertown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth Wallay</i>		ADDRESS <b>Chestertown, Md.</b>	
		25a. REC'D BY REGISTRAR <b>DATE APR 18 '61</b>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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FOR STATE  
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04389

1. PLACE OF DEATH  
a. COUNTY

Kent

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Chestertown - rural

c. LENGTH OF STAY IN lb

3½ hours

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Kent & Queen Annes Hospital

3. NAME OF  
DECEASED  
(Type or print)

First  
Victor

Middle

Last  
Danon

4. DATE  
OF  
DEATH April 9  
Month Day Year  
19 61

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

4/3/29

9. AGE (In years  
last birthday)

32  
yrs.

IF UNDER 1 YEAR

Months  
32

IF UNDER 24 HRS.

Days  
Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Staff Writer - USIA

10b. KIND OF BUSINESS OR INDUSTRY

US Govt.

11. BIRTHPLACE (State or foreign country)

Tel Aviv, Israel

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Danon

14. MOTHER'S MAIDEN NAME

Anna Haim

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

Yes

Korea

16. SOCIAL SECURITY NO.

17. INFORMANT

Joseph Danon 16 W. 86th St., N.Y.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Multiple severe injuries including

fracture of the base of skull .

INTERVAL BETWEEN  
ONSET AND DEATH

3½ hours

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

Was pilot in single engine plane which crashed near  
Chestertown, Md. with the above noted injuries.

(c) Death occurred 10:34 P.M.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour  a.m. 4/9 1961

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Rural, Chestertown Kent Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  , and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER  4/10/61 DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

Chestertown, Md.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-16-61

22c. NAME OF CEMETERY OR CREMATORIAL

King David Memorial Garden

22d. LOCATION (City, town, or country) (State)

Falls Church, Virginia

23. FUNERAL DIRECTOR

J.W. Willis Wells

ADDRESS

Chestertown, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE APR 17 '61

Arthur S. Kraus



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

04390

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN lb <b>1 hour</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne, Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>	
3. NAME OF DECEASED (Type or print) <b>Laura Elizabeth Downey</b>		4. DATE OF DEATH <b>April 26</b>	
First <b>Laura</b>		Middle <b>Elizabeth</b>	Last <b>Downey</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 14, 1890</b>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. FATHER'S NAME <b>Alec Shaney</b>	
13. MOTHER'S MAIDEN NAME <b>Mary Debering</b>		14. SOCIAL SECURITY NO. <b>579-22-6919</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. INFORMANT <b>Hospital records, Chestertown, Md.</b>	
17. ADDRESS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <b>Carcinoma of left breast</b> 3 years	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-26, 19 61, to 4-26, 19 61, that (I) (we) last saw the deceased alive on 4-26, 19 61, and that death occurred at 5 PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>A.C. Dick</i>		22b. DATE SIGNED <b>4-26-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.C. Dick, M.D.</b>		22d. ADDRESS <b>Chestertown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/26/61</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Wesley Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Rock Hall Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Elgar L. Lane</i>		25a. REC'D BY REGISTRAR DATE <b>MAY 3 '61</b>	
ADDRESS <b>Church Hill Md</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



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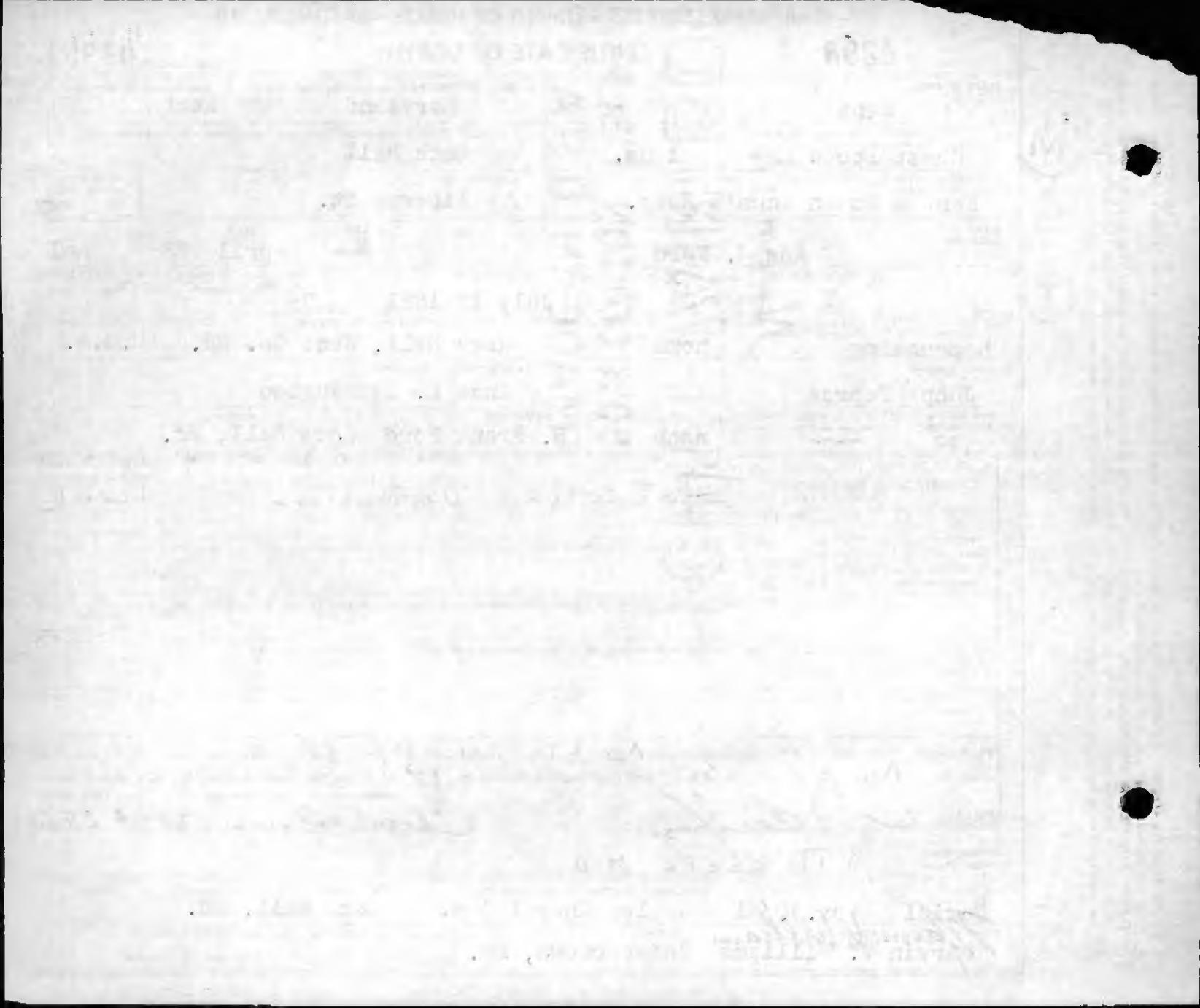
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4398

## CERTIFICATE OF DEATH

Reg. Dist. No. 04391

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 1 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Hall		d. STREET ADDRESS I Liberty St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hosp.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Ada S. Ford	Middle	Lost	4. DATE OF DEATH April 28	Month Year 1961	Day Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17 1881		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaking		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Rock Hall, Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Pearce		14. MOTHER'S MAIDEN NAME Anna E. Sappington					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ---	INFORMANT B. Frank Ford	Address Rock Hall, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <i>Intestinal Obstruction</i> DUE TO 570.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rock Hall	(County)	(State)
21. I certify that I attended the deceased from <i>Apr 27</i> , 1961, to <i>Apr 27</i> , 1961, that I last saw the deceased alive on <i>Apr 28</i> , 1961, and that death occurred at <i>11<sup>th</sup></i> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Chester Hall, Md.		DATE SIGNED <i>Apr 29, 1961</i>	
ACTUAL SIGNATURE <i>C. O. Steffens</i>		PHYSICIAN'S NAME (Type) A. T. Keepe, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 30/61	22c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel Cem.	22d. LOCATION (City, town, or county) Rock Hall, Md.			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin V. Williams</i>	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE MAY 2 '61	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

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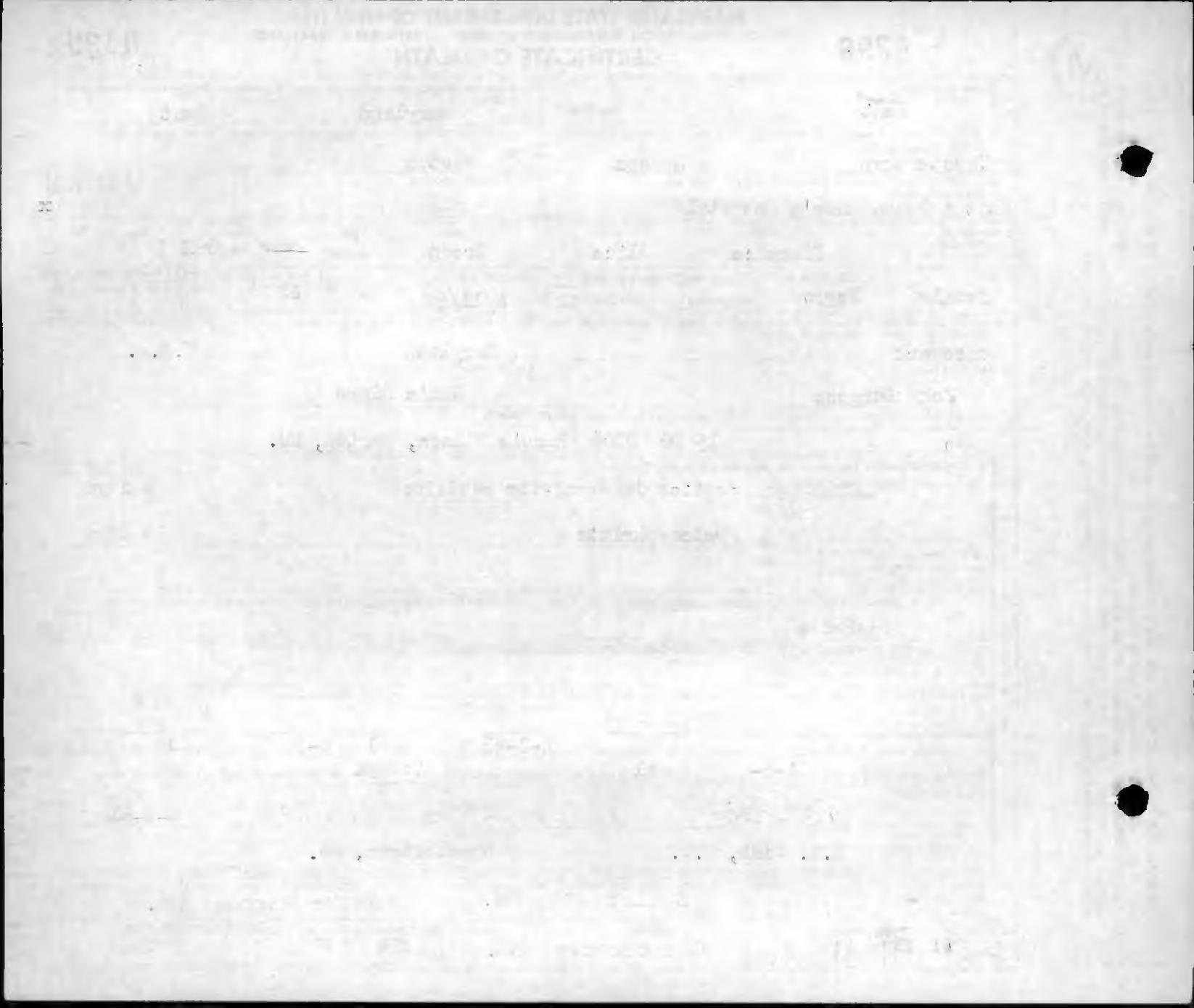
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4399

04392

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton		d. STREET ADDRESS RFD		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Florence		First	Middle	Last	4. DATE OF DEATH May April 5	Month	Day	Year 19 61
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/11/98		9. AGE (In years 62 on birthday) yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Burgess				14. MOTHER'S MAIDEN NAME Sadie Diggs				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 20 0106		17. INFORMANT Russie Wilson, Worton, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>600.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pyelonephritis</i> DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 6 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes								
6 days								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>4-1-61</i> , 19 61, to <i>4-5</i> , 19 61, that (I) (we) last saw the deceased alive on <i>4-5</i> , 19 61, and that death occurred at <i>7:20 pm</i> from the causes and on the date stated above.								
22a. SIGNATURE <i>A.C. Dick</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-5-61</i>				
22c. PHYSICIAN'S NAME (Type) A.C. Dick, M.D.		22d. ADDRESS Chestertown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/8/61		23c. NAME OF CEMETERY OR CREMATORIUM Butlertown, Md.		23d. LOCATION (City, town, or county) near- Worton, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth Waller</i>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR APR 10 '61 DATE		25b. REGISTRAR'S SIGNATURE <i>Charles L. Krause</i>		



FOR STATE  
HEALTH DEPT.

M

TO FUNERAL DIRECTOR Page 3 should be used as a burial-transit permit. It pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14393

1. PLACE OF DEATH

a. COUNTY  
Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Lynch

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN 16

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

April 19

19 61

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

male

white

WIDOWED DIVORCED 

7/24/1891

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreign language instructor

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Frank Karbaum

Karbaum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Jennie Karbaum, Minnie Shutte

Address

Lynch, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Probable Coronary Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH  
12 hoursConditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.(b) DUE TO  
Attack of precordial pain associated with shock and  
cold drenching sweat about 11:00 P.M. April 18, 1961.  
DUE TO  
Death occurred 10:30 A.M. April 19, 1961.PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I-e. 19. WAS AUTOPSY  
PERFORMED?YES  NO 20e. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 1920d. INJURY OCCURRED  
While at work  Not While at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Robert W. Farr

CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 

DATE SIGNED

4/21/61

22a. BURIAL, CREMATION  
REMOVAL (Specify)  
Burial

23. FUNERAL DIRECTOR

22b. DATE THEREOF

April 22, 1961

22c. NAME OF CEMETERY OR CREMATORIAL

Budderville Cemetery

22d. LOCATION (City, town, or county)

Budderville

(State)

ADDRESS

24e. REC'D BY REGISTRAR

Edward Ellwood-Willington

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraas

8

11

V V

V V

1  
FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it, certifying, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 shall be forwarded to the Chief Medical Examiner's Office along with form M-3. Page 1 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04394

## 1. PLACE OF DEATH

a. COUNTY

Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mear Chestertown

MARYLAND

c. LENGTH OF STAY IN lb

transient

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

## 3. NAME OF DECEASED (Type or print)

First  
Richard

Middle  
Irvin

Last  
Lindsay

## 4. SEX

male

## 6. COLOR OR RACE

White

## 7. MARRIED

NEVER MARRIED

## 8. DATE OF BIRTH

Oct 19, 1937

WIDOWED

DIVORCED

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

## 10b. KIND OF BUSINESS OR INDUSTRY

Campbell's Soup

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 13. FATHER'S NAME

Walter I. Lindsay

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

## 16. SOCIAL SECURITY NO.

215-36-1476

## 17. INFORMANT

E. Fellows, Millington, Md.

Address

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Internal injuries - chest and abdomen

INTERVAL BETWEEN  
ONSET AND DEATH  
short

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

Was in a car which failed to make a sharp turn in the road and upset, about 1:45 A.M. Deceased was thrown from the car & came to rest with the car resting on his abdomen & chest. He was dead when first seen after

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.  
moving the car. Spinal fluid was removed for toxicology.

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

## 20e. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m. 1:45 4/22 1961

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)  
(County) (State)

highway, rural Chestertown Kent Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion death resulted from Natural cause  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

*Robert W. Farr*

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME (Type)

Robert W. Farr, M. D.

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

4/22/61

## 22a. BURIAL, CREMATION REMOVAL (Specify)

## 22b. DATE THEREOF

Burial April 24 1961 Millington Cem. Millington, Kent Co., Md.

## 22c. NAME OF CEMETERY OR CREMATORIUM

## 22d. LOCATION (City, town, or country)

Millington, Kent Co., Md.

22d. LOCATION (City, town, or country) (State)

Millington, Kent Co., Md.

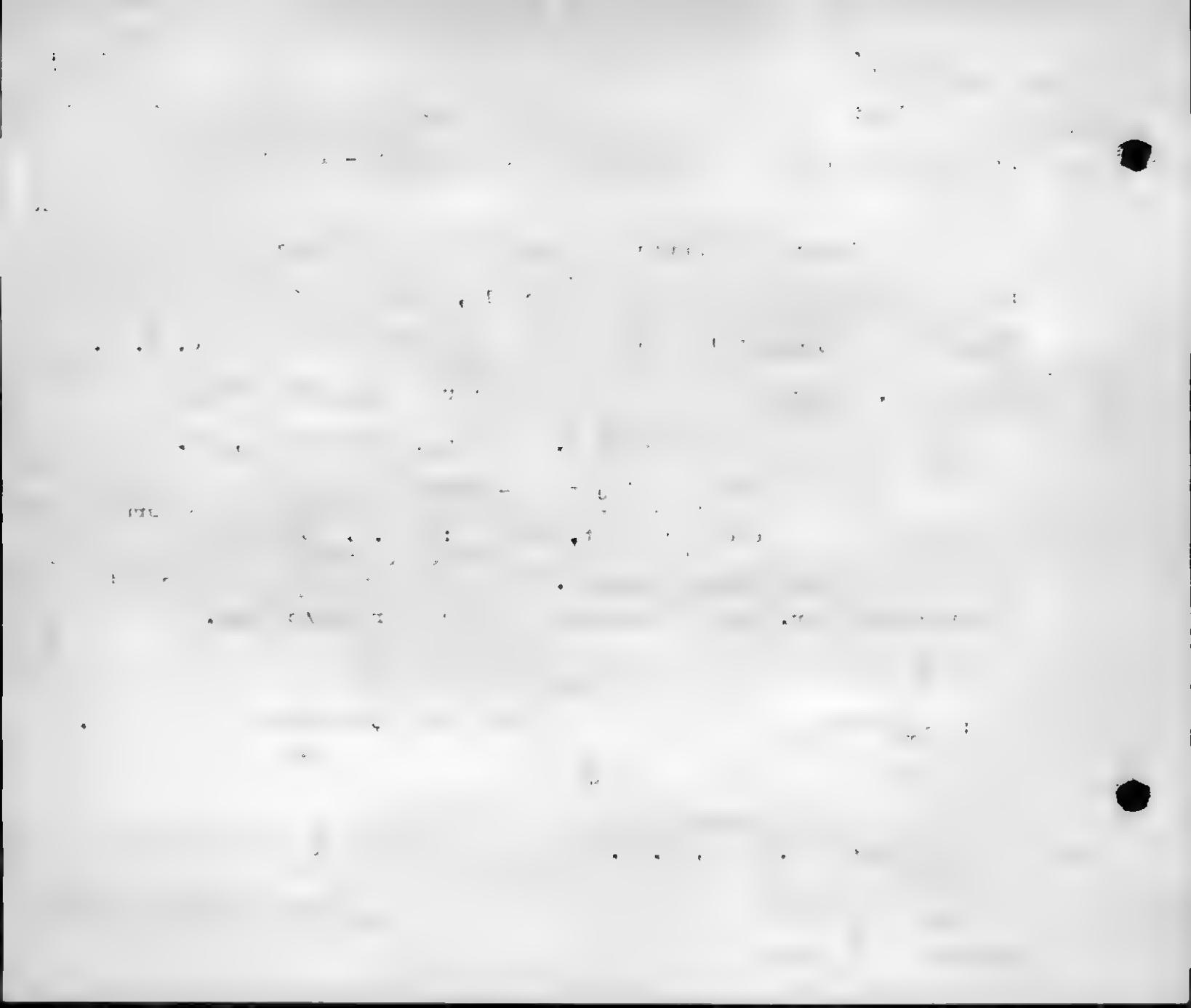
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

APR 25 1961

John S. Kean

VS. A15ME  
5M 7/59



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rebonded by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

04395

1. PLACE OF DEATH a. COUNTY		Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland b. COUNTY		Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				High Street					
3. NAME OF DECEASED (Type or print)		First Elizabeth	Middle Estelle	Last Peacock	4. DATE OF DEATH	Month 4	Day 8	Year 19 61	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/77		9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Fallowfield		14. MOTHER'S MAIDEN NAME Annie Cooper							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 063-09-8854		17. INFORMANT Elizabeth E. Peacock, Patient.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) Metastatic carcinoma 176-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inoperable squamous cell carcinoma of vagina 18 months DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-26, 19 60 to 4-8, 19 61, that (I) (we) last saw the deceased alive on 4-8-19 61, and that death occurred at 3:20 pm from the causes and on the date stated above									
22a. SIGNATURE <i>A.C. Dick</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 4-11-61					
22c. PHYSICIAN'S NAME (Type) A.C. Dick, M.D.		22d. ADDRESS Chestertown, Maryland							
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/12/61		23c. NAME OF CEMETERY OR CREMATORIAL Silverbrook Crematory		23d. LOCATION (City, town, or county) Wilmington, Delaware		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J.Willis Wells</i>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <i>Clinton S. Keane</i>			
APR 18 '61									



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

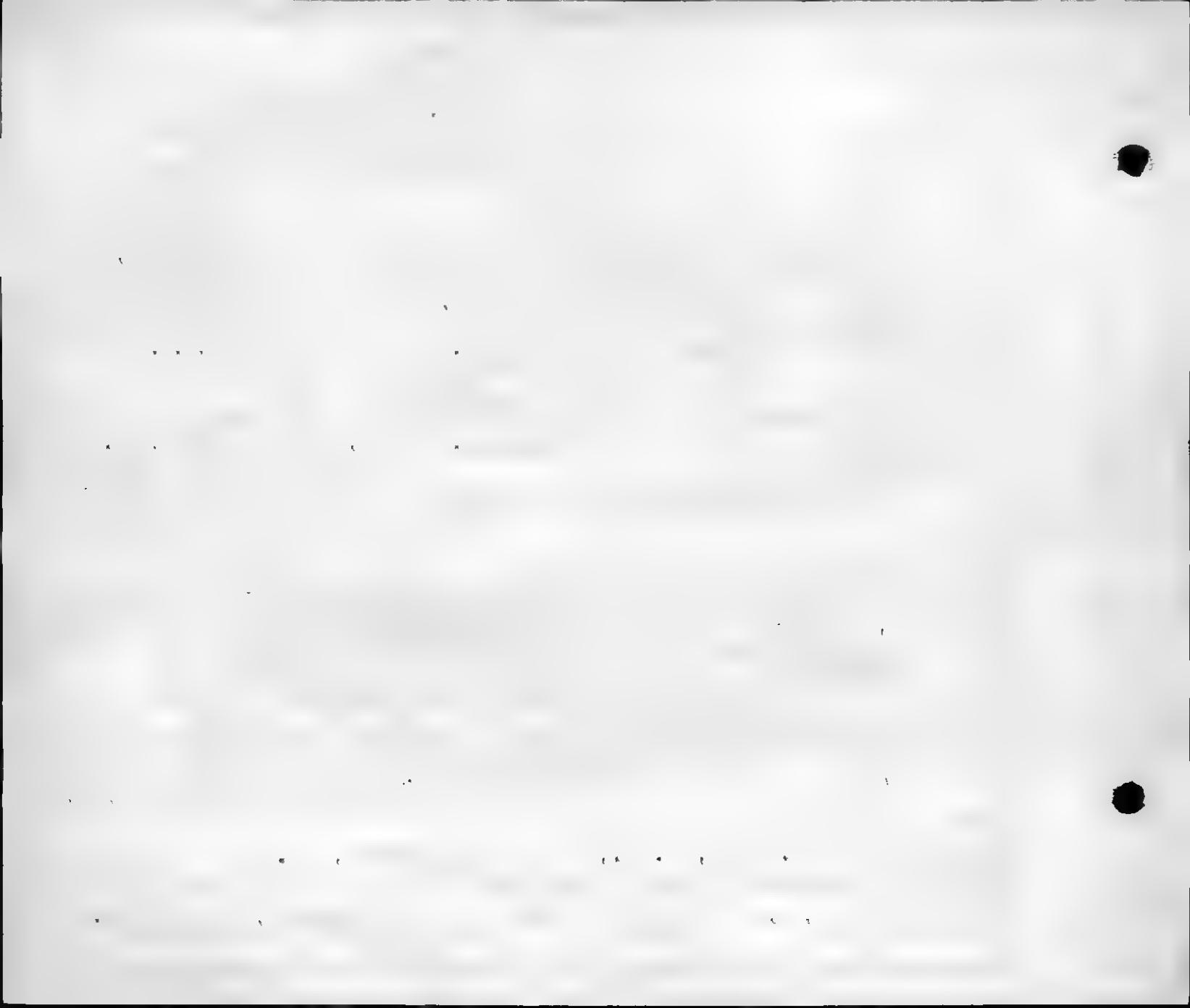


# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **04396**

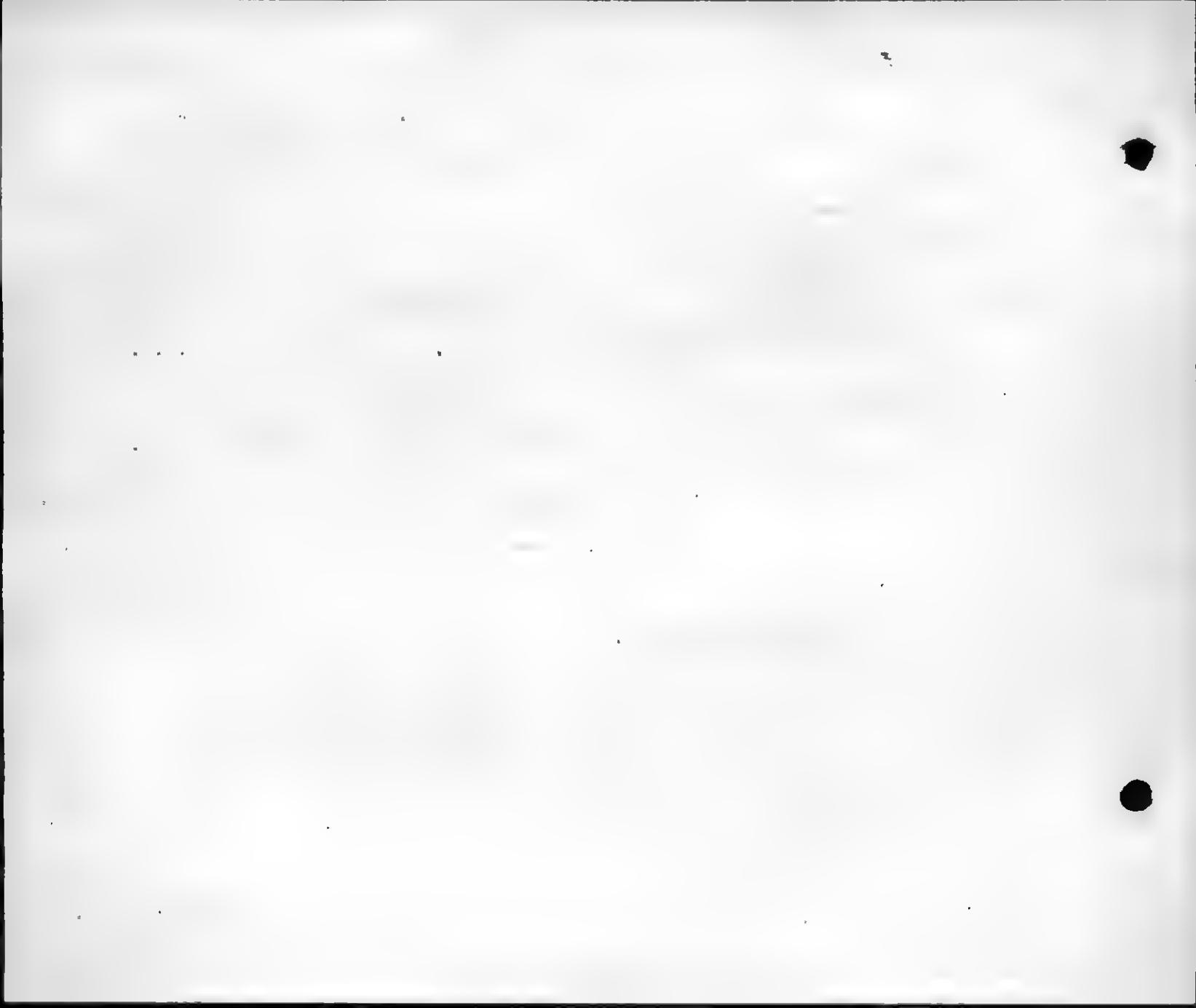
1. PLACE OF DEATH a. COUNTY <b>Kent</b>			2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennedyville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne Hospital</b>			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Lidie</b>	Middle <b>Davis</b>	Last <b>Rhoades</b>	4. DATE OF DEATH	Month <b>April</b> Day <b>28, 1961</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1874</b>	9. AGE (In years last birthday) <b>87 yrs</b>	10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> 11. IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
11. BIRTHPLACE (State or foreign country) <b>Del.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Cornelius Davis</b>			14. MOTHER'S MAIDEN NAME <b>Lizza Draper</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William B. Cleaver, Kennedyville, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatitis</b> DUE TO <b>Stricture of bile duct</b>			INTERVAL BETWEEN ONSET AND DEATH <b>27 days</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Uremia, Cachexia due to vomiting &amp; inability to eat</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Middletown</b> (County) <b>Del.</b> (State)	
21. I certify that I attended the deceased from <b>4/10</b> , 1961, to <b>4/28</b> , 1961, that I last saw the deceased alive on <b>4/28</b> , 1961, and that death occurred at <b>322 M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Robert W. Farr</i>		ADDRESS (Street, city or town, state) <i>M.D.</i>		DATE SIGNED <b>4/29/61</b>	
PHYSICIAN'S NAME (Type) <b>Robert W. Farr, M. D., Chestertown, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 30, 1961</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Forrest Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Middletown</b> (State) <b>Del.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellows</i>		ADDRESS <i>Millington, Md.</i>		24a. REC'D BY REGISTRAR DATE <b>MAY 2 '61</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												
CERTIFICATE OF DEATH												
Reg. Dist. No. 94397												
1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived—if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sassafras</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sassafras</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>					d. STREET ADDRESS <b>X</b>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First <b>Raymond</b>		Middle <b></b>		Last <b>Ringgold</b>		4. DATE OF DEATH <b>April 26, 1961</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 24, 1884</b>		9. AGE (In years last birthday) <b>76 yrs.</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Bus</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Perry Ringgold</b>					14. MOTHER'S MAIDEN NAME <b>Emma Driver</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <small>[If yes, give war or dates of service]</small>			INFORMANT <b>Elizabeth Ringgold,</b>			Address <b>Sassafras, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>12 hours.</b>  <b>years.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Severe generalized senility.</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cecilton, Md.</b>		20f. (City or town) (County) (State) <b>Cecilton, Md.</b>				
21. I certify that I attended the deceased from <b>5 Apr.</b> , 19 <b>61</b> , to <b>26 Apr.</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>26 Apr.</b> , 19 <b>61</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b>		
										DATE SIGNED <b>27 April</b>		
ACTUAL SIGNATURE <i>Wallace Obenshain</i>		PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>								Cecilton, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April, 29, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley Cemetery</b>		22d. LOCATION (City, town, or county) <b>Sassafras, Kent Co., Md.</b>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellows, Wellington, Md.</i>		ADDRESS <i>Edgar Fellows, Wellington, Md.</i>		24a. REC'D BY REGISTRAR <b>Cecilton, Md.</b> DATE <b>MAY 1 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Cecilton, Md.</i>						
VS A15 (4) 15M 9/58												



FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4405

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04398

1. PLACE OF DEATH

a. COUNTY Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chestertown Rural

c. LENGTH OF STAY IN lb

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF  
DECEASED  
(Type or print)

Sarah

First

Middle

Schmulman

Last

4. DATE  
OF  
DEATH April

Month

Day

Year  
19 61

5. SEX

female

6. COLOR OR RACE white

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

June 5, 1927

9. AGE (In years  
last birthday)

33 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Technician N.I.H. Inst. Health, Bethesda Md.

13. FATHER'S NAME

Jack Schmulman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of serv ce)

16. SOCIAL SECURITY NO.

17. INFORMANT

yes

Mrs. Frances Myman

12. CITIZEN OF WHAT COUNTRY?  
U.S.A. U.S.A.

14. MOTHER'S MAIDEN NAME

Ethel Kaminoff

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a) Multiple severe injuries including fracture  
of base of skull

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last. }  
(b) She was a passenger in a single engine plane which  
crashed near Chestertown, Md. with the above noted  
injuries. Death was probably instantaneous.

INTERVAL BETWEEN  
ONSET AND DEATH

none

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year (County) (State)  
Hours p.m. 7:20 4/9 19 61 Near Chestertown Kent Maryland

20d. INJURY OCCURRED While Not While  
at work at work   Near Chestertown

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

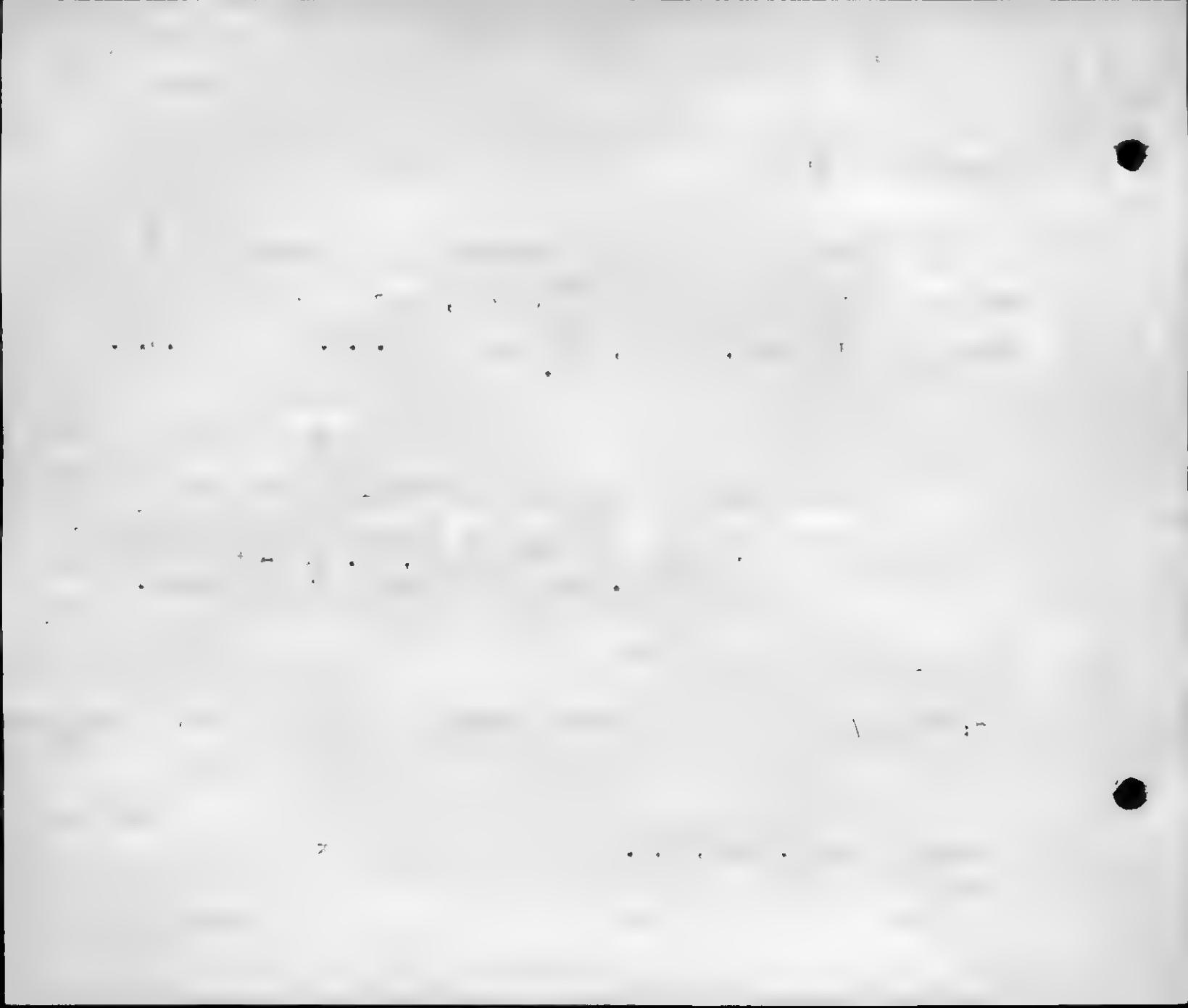
April 10/61

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or country) (State)

Burial 4/11/61 Eden Memorial Park Los Angeles, Calif.

23. FUNERAL DIRECTOR ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Willis Wells Chestertown, Md. APR 18 '61 Arthur S. Krause



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4406

## CERTIFICATE OF DEATH

Reg. Dist. No. 04399

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

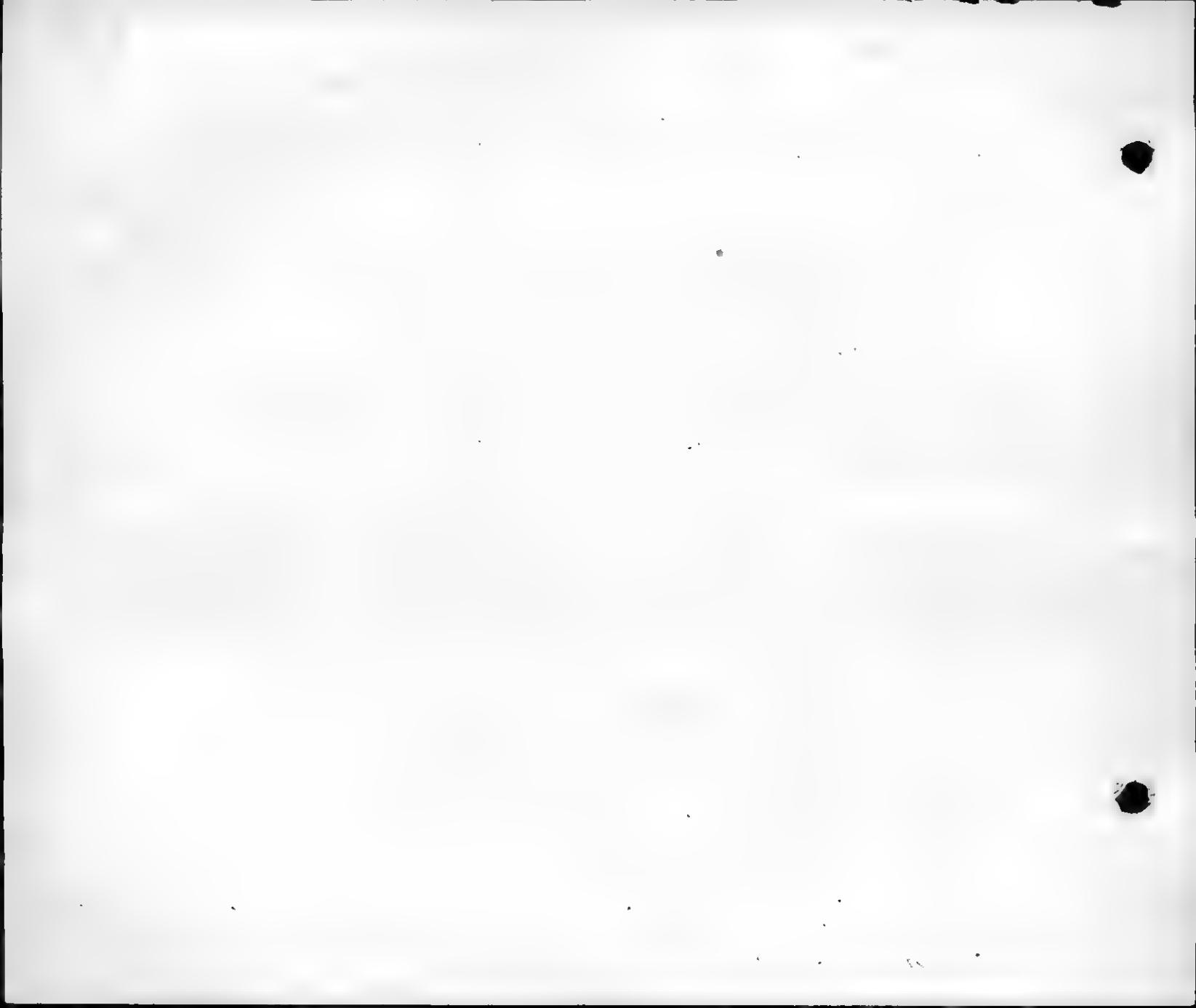
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

X

I

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Kent County</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
<i>Rock Hall, Md.</i>		<i>Rock Hall</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
		<i>Green Lane</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Annie</i>			<i>Sewell</i>
4. DATE OF DEATH	Month	Day	Year
<i>Feb 12</i>	<i>4</i>	<i>19</i>	<i>1961</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>F</i>	<i>W</i>		<i>Feb 12 1872</i>
9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
<i>89 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>House wife</i>		<i>Md</i>	<i>US</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Rodolph Wesley</i>	<i>Unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INTERVIEWER	Address
	<i>None</i>		<i>MARION SEWELL Rock Hall</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>194X</i> DUE TO <i>Senility</i> INTERVAL BETWEEN ONSET AND DEATH <i>one week</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Rock Hall, Md.</i> DATE SIGNED <i>2/24/61</i>	
ACTUAL SIGNATURE <i>E. Kester</i>		PHYSICIAN'S NAME (Type) <i>E. KESTER</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/20/61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Wesley Chapel</i>
22d. LOCATION (City, town, or county) <i>Rock Hall</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane Church Hill Md.</i>		24a. REC'D BY REGISTRAR <i>APR 24 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

04400

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN lb <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chestertown</b>		d. STREET ADDRESS <b>RFD#2, Fairlee</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>H.</b>	Last <b>Toulson</b>	4. DATE OF DEATH <b>April 13</b>	Month	Day	Year <b>1961</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5/30/76</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas W. Toulson</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Baker</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>William H. Toulson, (Patient).</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery infarct</b> INTERVAL BETWEEN ONSET AND DEATH 30 min.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>+ 20</b>		DUE TO (b) <b>Coronary artery disease</b>				2 years	
		DUE TO (c) <b>Arteriosclerosis</b>				10 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-8-1961</b> to <b>4-13-1961</b> , that (I) (we) last saw the deceased alive on <b>4-12-1961</b> , and that death occurred at <b>2:05 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A.C. Dick, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-13-61</b>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Chestertown, Maryland.</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Chester Cem.</b>		23d. LOCATION (City, town, or county) <b>Chestertown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Kline</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 04401

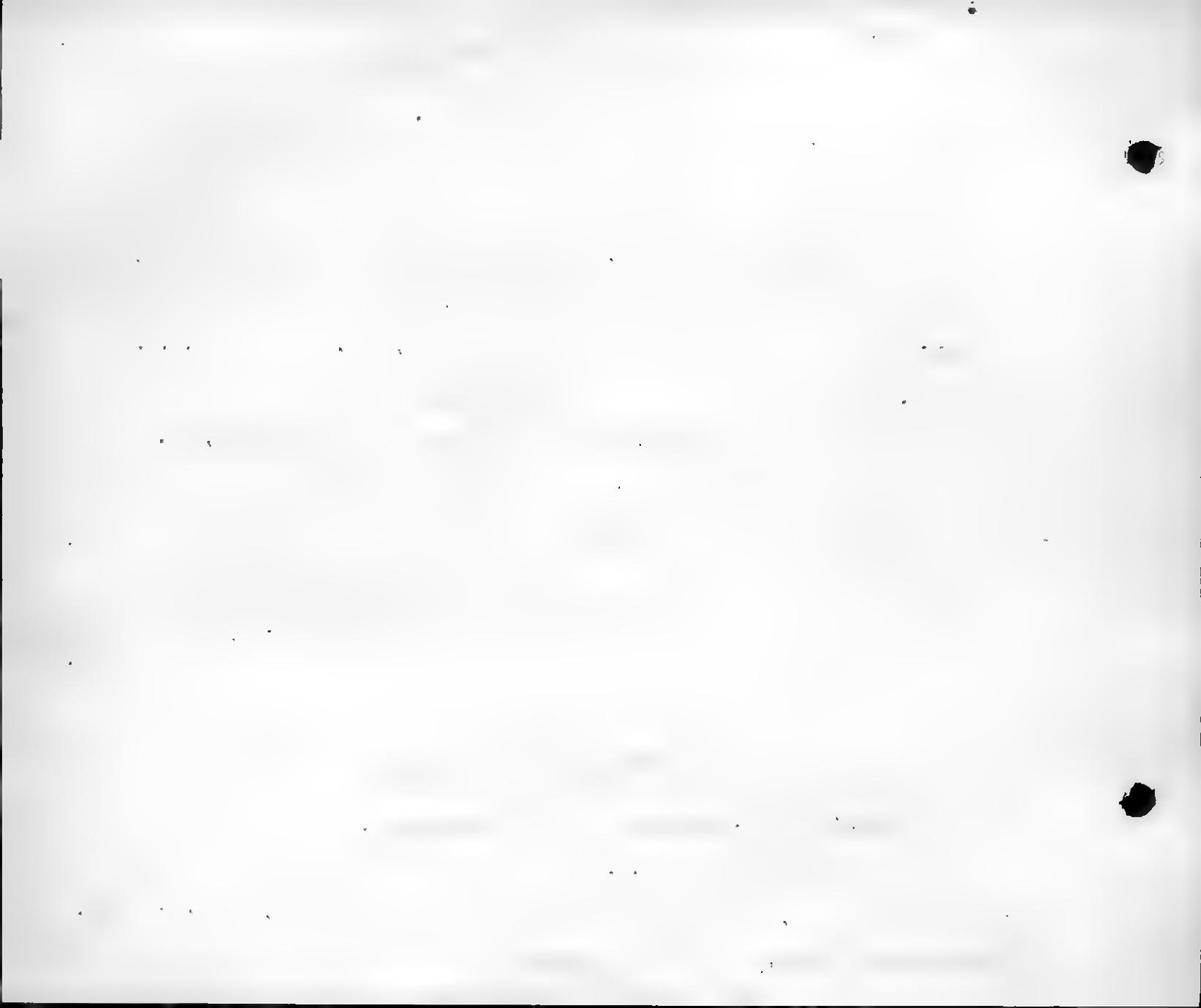
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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1. PLACE OF DEATH a. COUNTY <b>Kent</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Lula</b>	Middle <b>M.</b>	Last <b>Wallace</b>	4. DATE OF DEATH <b>April</b>	Month <b>4</b>	Day <b>1961</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1895</b>	9. AGE (in years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b> Min. <b>0</b>
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Millington, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George H. Dixon</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-20-0586</b>		INFORMANT <b>Ward Wallace,</b>		Address <b>Millington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> INTERVAL BETWEEN ONSET AND DEATH DUE TO <b>5/21</b> 3 days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Emphysema</b> years. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? <b>Extreme anorexia, malnutrition, generalized arteriosclerosis, intestinal claudification.</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACC.DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 16, 1960</b> , to <b>4 Apr, 1961</b> , that I last saw the deceased alive on <b>4 Apr, 1961</b> , and that death occurred at <b>3:00PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED <b>5 Apr 61</b>							
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D. Cecilton, Md.							
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 7, 1961</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Millington Cemetery</b>		22d. LOCATION (City, town, or county) <b>Millington, Kent Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		ADDRESS <b>Millington, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Edward S. Kline</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4409

## CERTIFICATE OF DEATH

Reg. Dist. No.

04402

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)		a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
Chestertown		4 Mo.		Kennedyville		II			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Kent & Queen Anne Hosp.		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Mary Louise Weer					April 18			1961	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.	
F.	W.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 18, 1886	75					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
housekeeping		homemaking		Kent Co. Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
James Johnston		Annie Jefferson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		INFORMANT		Address			
-----		none		Miss Marie Weer		Kennedyville, Md.			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		113 days	
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cerebral thrombosis with left sided paralysis	
DUE TO			
(b) arteriosclerosis		??	
DUE TO			
(c)			

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
---	--	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19		While at work <input type="checkbox"/>	

21. I certify that I attended the deceased from 12-26, 1960, to April 18, 1961, that I last saw the deceased alive on 4-17, 1961, and that death occurred at 6:15 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

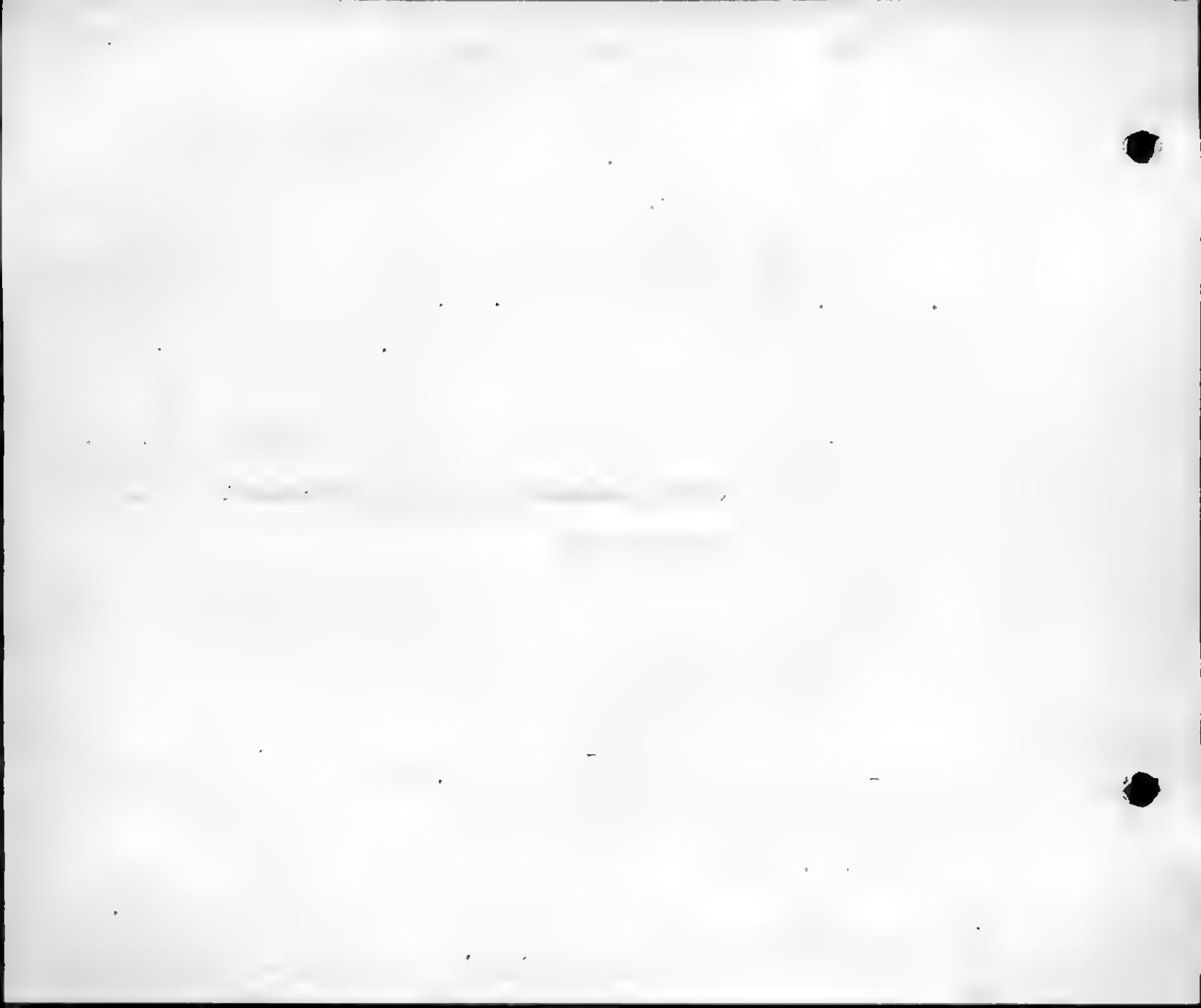
DATE SIGNED

ACTUAL SIGNATURE *A. C. Dick* M.D.

PHYSICIAN'S NAME (Type) A. C. Dick

Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/20/61	22c. NAME OF CEMETERY OR CREMATORIUM Kennedyville Cemetery	22d. LOCATION (City, town, or county) Kennedyville, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE APR 21 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

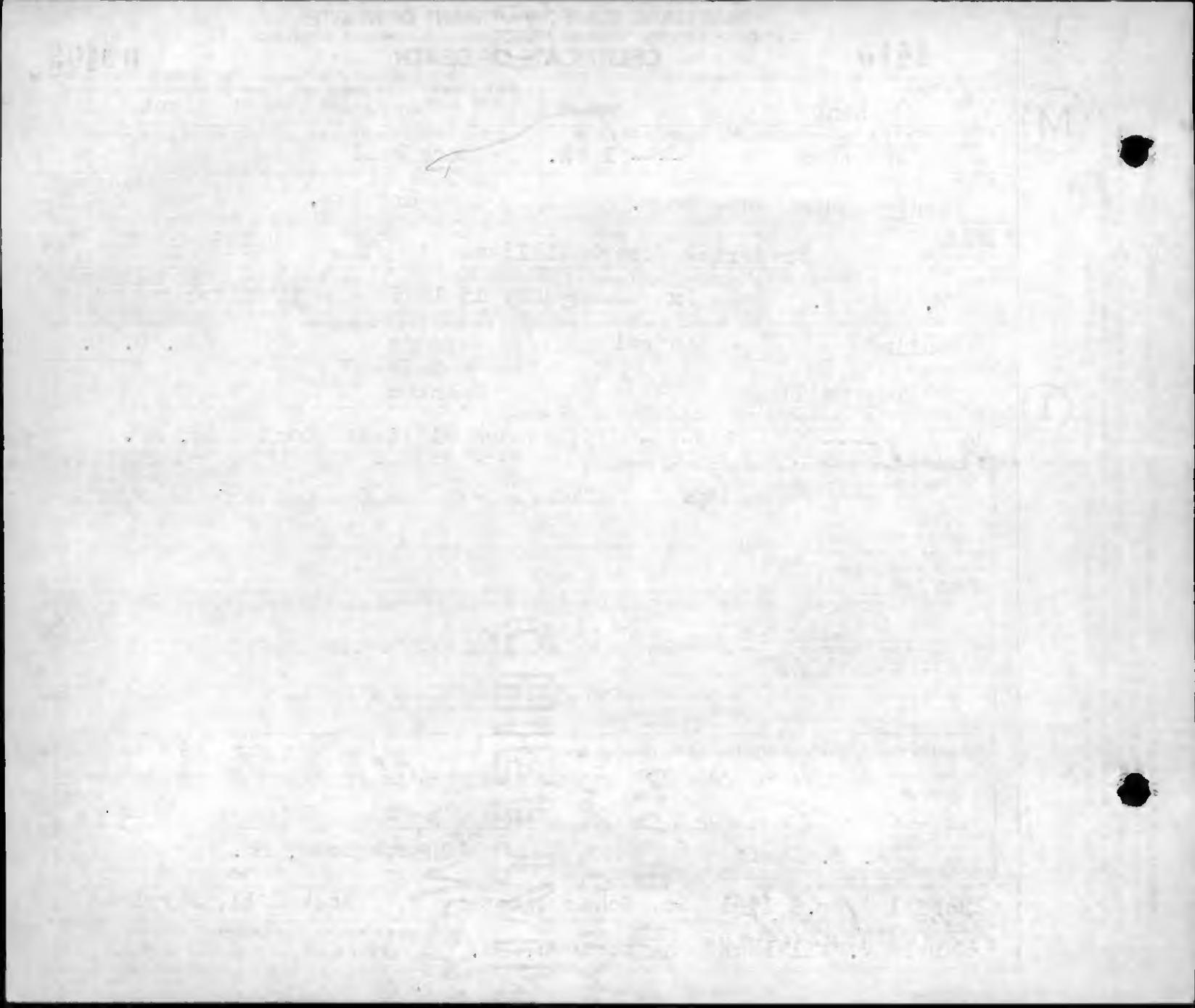
1  
B  
M  
022  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

04403

1. PLACE OF DEATH o. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b -75- 1 Wk.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
3. NAME OF DECEASED (Type or print)		First Frederick Joseph Williams	Middle Lost
4. DATE OF DEATH Month April		Day 4	Year 1961
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hauling		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (State or foreign country) Germany
13. FATHER'S NAME Godfrey Williams		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-20-0235	17. INFORMANT Joseph Williams Rock Hall, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH years <i>Generalized Arteriosclerosis</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4.1</u> 19 <u>61</u> , to <u>4.4</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4.4</u> 19 <u>61</u> , and that death occurred on <u>4.4</u> 19 <u>61</u> , from the causes and on the date stated above.		22b. DATE SIGNED 4.5.61	
22a. SIGNATURE <i>A. T. Keefe</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS Chestertown, Md.
22c. PHYSICIAN'S NAME (Type) A. T. Keefe			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 8 1961	23c. NAME OF CEMETERY OR CREMATORIALy St. Johns Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR DATE APR 10 '61
			25b. REGISTRAR'S SIGNATURE <i>Charles L. Keefe</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4411

## CERTIFICATE OF DEATH

Reg. Dist. No.

04404

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Kent MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Maryland	b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Worton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		50 years	d. STREET ADDRESS		Worton, Williams Farm				
3. NAME OF DECEASED (Type or print)		First Isabelle	Middle V.	Last Williams	4. DATE OF DEATH	Month April	Day 11	Year 1961	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours		
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	September 10, 1888	72 yrs.	Days	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Homemaking		Kent county, Maryland		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Thomas Van Dyke		Regina Rasin							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT		Address			
		215-20-1039		George T. Williams, Worton, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH 6 months		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Metastatic cancer							
199X									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Original focus unknown							
(b)									
DUE TO									
(c)									
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
Coronary artery disease									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy 19	Year 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chestertown, Md.	(County) Chestertown, Md.	(State) Maryland
21. I certify that I attended the deceased from		1-26		19 61	to	4-11	19 61	that I last saw the deceased alive on	4-4 1961
ACTUAL SIGNATURE		<i>A. C. Dick</i>					ADDRESS (Street, city or town, state) Chestertown, Md.		
PHYSICIAN'S NAME (Type)		Dr. A. C. Dick					DATE SIGNED 4-12-61		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
Burial		Apr. 14/61		Chester Cemetery		Chestertown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
<i>Marvin V. Williams</i>		Chestertown, Md.		DATE APR 17 '61		<i>Arthur S. Knapp</i>			

